Duals Care Delivery Workgroup
May 2, 2016

Introduction

The meeting began at 1:00 pm. Shannon McMahon (Deputy Secretary, Health Care Financing, DHMH) provided a welcome to the workgroup, which was followed by introductions and a recap of events since the April meeting. At that meeting, the EBG Advisors team (consultant to DHMH) had overviewed three straw models for a care delivery strategy for dual eligibles: 1) Managed Fee-For-Service (MFFS), 2) an Accountable Care Organization (ACO) and 3) Capitation. Since then, DHMH and EBG had convened a subgroup focused on defining care coordination in the context of the duals. Additionally, DHMH had released a feedback tool to stakeholders, consisting of an exercise to evaluate the three straw models presented against the stated guiding principles for the resulting model. DHMH received six responses to this exercise, which it reviewed.

Defining Care Coordination

- Dale Schumacher (Consultant, Rockburn Institute) presented an overview of the conclusions reached by the care coordination subgroup, which consisted of eight volunteer members of the greater workgroup. The definition is based on the Agency for Healthcare Research and Quality's (AHRQ) definition, which shifts away from a medical model to the determinants of care. No comments were received from the workgroup on the proposed definition; this definition will thereby be used going forward as the working definition for care coordination. The workgroup did want to underscore the meaning of 'people who could benefit.'
- Adrienne Ellis (Director Healthcare Reform and Community Engagement, Mental Health Association of Maryland): How to decide who will get those resources? (Dr. Schumacher: Strategic, tactical and operational approach to stratification will be rolled out in future meetings.)
- Leah Hirsch (Senior Director, Medicaid Government Relations Business Development, Amerigroup): What is the basis for these measures? (Dr. Schumacher: The measures are largely based on National Quality Forum (NQF) measures, federal expectations under IMPACT 2014, 33 measures for ACOs, CPC+. We focused on matching quality measures with data availability and programmatic priorities—balancing reducing provider burden with meeting CMS expectations.)
- Scott Rifkin (CEO, Mid-Atlantic Healthcare): Transitions of care are a key issue.
- Bob Atlas (Consultant, EBG Advisors): We will need to translate these in to scope of work of future contracts for care coordinators.

Review of Models: Managed Fee-For-Service

- Bob Atlas (Consultant, EBG Advisors) highlighted changes to the model since the previous meeting. Regional Care Coordination Entities have been redefined as Care Coordination Entities, as the selection of a statewide vs. regional model would be determined if the MFFS model is selected. Mr. Atlas clarified the concept of patient-centered medical home vs. primary care

medical home; the duals model will encompass the former. Lastly, disparate funding streams have been redirected to all flow through DHMH.

- Adam Kane (Senior Vice President, Corporate Affairs, Erickson Living): Do these changes reflect our conversations with CMS? (Mr. Atlas: To a certain extent, but not the bulk of them. (Tricia Roddy, Director, Planning Administration, DHMH: We just gave them a taste of the straw models—they did not give guidance on the models but on the process of how to work with them to request authorities.)
- Laura Herrera-Scott (Medical Director, Population Health, Johns Hopkins HealthCare, LLC): How are we defining patient-centered medical home? Will we use the National Committee for Quality Assurance (NCQA) approach? (Mr. Atlas: We have not gotten that far yet. We are hesitant to use NCQA because of its limitation to primary care. We welcome inputs and suggestions.)
- Lori Doyle (CEO, Mosaic, Inc.): You can use the Chronic Health Homes (CHHs) as an example. The providers directly receive the $98. In this diagram, the monies would flow through CCE and then down to the provider—would the amount the CHH providers receive be reduced because it is flowing thru the CCE? (Mr. Atlas: The CCE is there to help the PCMHs perform their function and serve as a resource; it will need to be funded somehow.)
- Which duals should be enrolled in MFFS
    - Mr. Kane: We will need more discussion on if we are excluding existing ACO members. (Mr. Atlas: Because MSSP existed first, we do not want to overstep. This could change.) Mr Kane: We might want to—they are not helping the Medicaid side. (Ms. Roddy: We have some numbers—the are 17,000 duals enrolled across existing ACOs.) We do not know how successful they have been managing the duals. (Mr. Atlas: Should we take this as a suggestion for removing the duals from the ACOs?)
    - Debi Kuchka-Craig (Corporate Vice President, Managed Care, MedStar Health): [Disagreed.] This seems to be suggesting that newly-designated duals are capped and more could not join existing ACOs. There is lots of investment being made. (Mr. Atlas: Yes, we need to make these decisions.)
    - Teja Rau (Chief, Long Term Care Services and Supports, Maryland Department of Aging): Would duals in a CSA be integrated into this? (Tricia: Everything would be integrated. Once we choose a model, need to figure out how to integrate all of the existing programs and resources.)
- Patient-Centered Medical Home (PCMH)
    - Marie Grant (Director, Strategic Communications, CareFirst BlueCross BlueShield): Does the Interdisciplinary Care Team (ICT) reside within the PCMH or the CCE? (Mr. Atlas: I am not really familiar with the ICT, but it seems that when you identify a comprehensive care plan for a beneficiary, you develop a patient-specific team.)
    - Ms. Doyle: Would you honor current relationships? The CHH program is voluntary, and we would not want people to get recruited away. (Mr. Atlas: In my mind, less disruption is better. We want to preserve care patterns so long as they are functional.)

- Ms. Kuchka-Craig: It would be helpful to further delineate the duties of the CCE as it relates to PCMH. Normally many of these duties are embodied in the PCMH, which is different from what the slides present. (Mr. Atlas: Yes, it is a little bit of an enrollment function, but not a heavy-duty process like an enrollment broker. The CCE may be better-positioned to identify a relationship for a beneficiary.)

- Role of CCE as a wrap-around and enforcer for PCMHs
  - Mr. Kane: Where does prior authorization fit? (Mr. Atlas: CMS noted that there is no place for that in Medicare, but perhaps somebody needs to be doing some kind of prior-authorization or utilization management.) How does it work in FFS? (Ms. Roddy: We have this for our FFS population but not for the duals. Is this something we should be looking at for them on the Medicare side?) Mr. Kane: It may be less complicated to look at people not using services effectively. (Mr. Atlas—Like a legitimate exceptions basis instead of up front. Many MFFS programs do not necessarily get you return on investment (ROI). Comprehensive Primary Care (CPC) has some positive findings but not much ROI. Preliminary results in Washington State are showing some single-digit ROI.)
  - Ms. Ellis: Could we modify previous like to all services, not just health? (Yes, this will be changed.) On utilization review, due process becomes very important. Who are we as consumer representatives going to be appealing to? (Mr. Atlas: Duals have rights that are Medicaid-specific and Medicare-specific; this is very complicated.)
  - Joe DeMattos: FFS pre-authorization is generally problematic—retrospectively vs. prospectively, based on utilization. I agree with Adrienne's note of due process. A Government Accountability Office study identified need for greater oversight of due process. (Ms. Roddy: The FFS program has concurrent review process.)
  - Ms. Hirsch: There is FFS appropriate use criteria for imaging services. Medicare putting out guidelines.
- Payment for care coordination
  - Mr. Atlas: Care coordination will need to be funded out of projected savings—CMS has indicated a need for budget neutrality. We could perhaps look at throwing Medicare chronic care management (CCM) fees into a pot prospectively initially instead of billing for it.
  - Dr. Herrera-Scott: How would the co-pay work? (Mr. Kane: Medicaid pays it.)
  - Mr. Kane: We are having success in billing CCM.

Review of CPC and CPC+

- Donna Kinzer (Executive Director, HSCRC): Doctors who get into CPC+ are considered to meet the MACRA requirements as an APM, according to the proposed rule.
- Ms. Roddy: June 1st is the letter of intent; proposals are due later in the summer. We can convene the discussion, but it is payer-initiative. (Mr. Kane: Is Medicaid considered a payer for this?) On the FFS side, yes. Most are duals, so it would not work. Our MCOs would have to initiate letters as well. We would have to look into if it would be a budget initiative.
- Ms. Kuchka-Craig: What is the number of ACOs? (Mr. Atlas: 33, but only 20-22 are Maryland-based.) How many physicians would be linked with these ACOs, because those physicians are

not eligible for CPC+? (Mr. Atlas: We would like to see if what we design will qualify physicians, including current MSSP physicians. Per the proposed MACRA rule, CPC+ are included, Track 1 ACOs are not on the list, and Track 2 ACOs are on the list (only about 1% of current ACOs.) If they would not qualify for MACRA, maybe they're not excluded from CPC+? We need to find out.

- Ms. Kinzer: The other question is if we could ask for a waiver to allow ACO physicians to participate, because CPC+ makes sense in the context of an ACO.
- Ms. Roddy: A challenge we will have as we think through is that it will probably not be statewide—we need to figure out how to integrate it into a larger program
- Mr. Kane: If we could gauge what CMS is thinking, we could figure out how to determine what kind of principles to integrate into our program. (Mr. Atlas: We did discuss with them that what we design we would like to qualify.)
- Maansi Raswant (Director, Policy and Data Analytics, Maryland Hospital Association): This dialogue highlights how many uncertainties we have. I would caution us to think through these pieces first before going ahead and asking for a waiver. (Mr. Atlas: Could you be more specific?) Earlier we said MSSP ACO-enrolled duals would be carved out, now we are discussing not carving them out. There is confusion on how these ACOs play with the All-Payer Model. (Mr. Atlas: An issue is how to include how to integrate into the All-Payer Model.)

Review of Models: Duals Accountable Care Organization

- Ms. Kuchka-Craig: You should talk to ACOs to ask them what their experience has been. (Ms. Roddy referenced Medicaid's efforts to get the names of ACO-enrolled duals, asking that if MedStar could identify their enrolled duals, that would be helpful.) Will the data analysis be in-house? (Yes, we will look at utilization patterns.) That is not going to tell you the challenges. (Mr. Atlas: These are not mutually-exclusive activities. The ACO only sees them from the Medicare point of view. We did not confine ourselves to the MSSP model.) (Ms. Roddy: With MedStar's ACO, how do you coordinate with the Medicaid side, if at all?) I do not know the answer to that, but I know our number of duals and their profiles. Our clinical team is working really hard to bend the curve and get them the right care.
- Mr. Kane: Would Medicaid know the effect of ACOs on utilization on costs? (Ms. Roddy: That is why we are eager to get the names of the enrollees.) We need to be cognizant of cost shifts. (Ms. Roddy: Yes, one of our guiding principles is the total cost of care (TCOC).)
- Ms. Rau: I am curious on how the ACOs are working with the long-term services and supports (LTSS) population—those discharged back to the community. (Mr. Atlas: In conversations I have had with ACOs, when asked about getting involved in LTSS, I get the evil eye. It is not necessarily part of their domain.)
- Mr. Atlas: ACOs will not necessarily cover all geographic areas—we could consider combining the MFFS and ACO models together.
- Ms. Raswant: In areas not covered by D-ACOs, would the mandating not apply? (Mr. Atlas provided an example using a county.)

- Mr. Kane: You expressed desire for uniformity in the MFFS, but in the ACO context, the model is much more diffuse (any willing ACO). (Mr. Atlas: We would assume that a duals ACO would not be that entity's only line of business.)
- Ms. Grant: How would the networks work? For Medicare ACOs, there is freedom of choice. (Mr. Atlas: There is freedom of choice for Medicare and Medicaid. The reality is that there is no penalty that you can apply to those going outside the network—this is true in regular Medicaid managed care. It is difficult to keep people in-network. It is up the ACO providers to try and keep people in-network.) (Ms. Roddy: An example could be CareFirst's program—give the providers tools to encourage a particular utilization.)
- Ms. Kuchka-Craig: Are we getting rid over the oversight/utilization function of the CCE? (Mr. Atlas: The CCE could go away for take on role to be the state's agent to coordinate the ACOs. CCE could have that binary function—plus administering MFFS in areas without ACOs.) I worry about the expense of setting up CCEs and ACOs that keeps providers from focusing on providing quality care and care coordination. (Mr. Atlas: [Referenced HSCRC's ICN] Maybe there is a hint of an opportunity for these to morph into one entity.)
- Review of quality measures
    - Dr. Schumacher reviewed the quality measures, which are intended to be interoperable with reporting requirements of other programs
    - Dr. Herrera-Scott: Have these been crosswalked with new CMS measures for PCMH, ACOs, etc.? (Yes.) Will we see where the overlap is? (We have a lot of lifting to do in this area, but we need to consider what data is available from CRISP and Hilltop, etc.)
    - David Horrocks: What portion can be calculated from claims data? (The specifications are available for each one of them—we need to look into them.)
    - Mr. Atlas: This is a list of measures for consideration, not final. There will be compromises. Also, you cannot choose all these measures on day one.
    - Ms. Kuchka-Craig: For the next iteration, could we see which ones match? To David's question, could we look at the data source? (Yes.)
    - Ms. Doyle: It is very refreshing to have behavioral health measures already in there.
    - Ms. Hirsch: One category missing is LTSS. It would be good to see more into the effectiveness of the care coordination provided. (Dr. Schumacher: NCQA is supposedly providing a new LTSS list in July.)
    - Ms. Kinzer: About a quarter are diabetes—why the focus? (Dr. Schumacher: Diabetes and heart failure correlate with rates of admissions for ACO and non-ACO beneficiaries.) (Ms. Doyle: [Explained clinical issues surrounding serious mental illness (SMI) and diabetes])
    - Ms. Doyle: I would be remiss if I did not say that people with SMI have really terrible health outcomes; there is something to be said for segmenting the population this way. (Dr. Herrera-Scott: They would still be captured in the denominator.)
- Payment
    - Dr. Rifkin: How is refined the distribution? Cost in rural areas and city are very different. (Mr. Atlas: You want to make it as accurate as possible for the person you are serving, but not so granular that the law of large numbers does not apply.) (Ms. Kinzer: Would we be

thinking about that for Medicare and Medicaid? It would be different from the Medicare and Medicaid MCOs, not just built upon the cost of the health spend.) (Mr. Atlas: It would not be an actuarial analysis but would be reflective of the spending experience.)

- Risk-sharing
  - Mr. Atlas: This model tracks against select aspects of MSSP Track 2
  - Ms. Doyle: Have you find any models in terms of risk-adjustment for people with SMI? (Mr. Atlas: We have not done enough research to know. I agree that there is likely very little research in this. North Carolina and Washington have capitated behavioral problems—we could take a look.
  - Jennifer Eastman (Director of Community Living Policy, Maryland Department of Disabilities): If D-ACOs are expected to share savings, and DHMH is not mandating this, how will this be monitored? (Mr. Atlas: We could decide on how rigid we would be in pushing this. We could require upfront in application process what is their payment scheme, then in evaluation, look into it. We do not want to reward them based on their volume.)
  - Dr. Rifkin: A lot of experience with Bundled Payments for Care Improvement (BPCI) [Maryland is not allowed to do these]—in setting up gainsharing programs and looking into which providers affect TCOC.
  - Mr. Kane: Will the ACO have downside risk for providers? And this would qualify them for MACRA? (Mr. Atlas: That is the idea.)
  - Ms. Grant: Have you compared this model with MACRA? (Mr. Atlas: Thus far in our study of the proposed rule, we have determined that Track 2 ACOs do qualify.)
  - Ms. Kinzer: To turn this into dollars, there is about $4 billion on duals across Medicare and Medicaid. It would be $400 million of downside risk. (Mr. Atlas: It would be ACO-specific, but on aggregate, yes.)
  - Mr. Kane: Where does the CHH payment fit into this calculation? (Mr. Atlas: We could put it in both numerator and denominator, or leave it out.)
  - Ms. Kuchka-Craig: How do we assess the providers' readiness to take on downside risk? (Mr. Atlas: MACRA says providers have to take downside risk to qualify for APM payment.) Who backs them up when the money is not there to pay them back?
  - Dr. Rifkin: We will step up. The nursing home community has an I-Skilled Nursing Facility (SNF).
  - Joe DeMattos (President and CEO, Health Facilities Association of Maryland): The most intriguing model is the ACO model, but we have to protect baseline funding and have both upside and downside risk. We could not do an initial reduction in payment. Providers want stability and predictability and are adaptive. Some are more flexible than others, but it is a growing group.
  - Mr. Kane: It is not just the numbers but the simplicity and uniformity of the program. What inhibits provider participation is having to work in multiple programs.
  - Ms. Raswant: I agree, and there is also a need to be successful. This model is something other states have not done. We are transforming care in this other massive way. We should learn from what other states have done and try those things, like MFFS.

Review of Models: Capitated Plans

- Mr. Atlas: Most of what we are proposing is not new—we added additional detail on the ICT and appeals/grievances process. CMMI has not shown particular interest in this model; they want to do something innovative. We have examples of this model from the duals demos—70% of beneficiaries have opted out. We are left with MLTSS plans, which could be good but is not really what we are looking for..

Comparison of the Three Models

- Ms. Grant: I would suggest that first bullet under disadvantages for MFFS depends on how you set up the model.
- Ms. Doyle: Are there any implications with these models in terms of MMIS's capabilities? (Ms. Roddy: We have to sit down with our operations folks, but if we were trying to lock individuals into a provider network, there would be challenges.)
- Dr. Rifkin: When ACOs came out, we tried to promote facility-based ACOs, as opposed to providers. Are there any thoughts on this? (Mr. Atlas: That has already been done: If people are in custodial care, who is the likely PCMH? Those providers doing rounds in those facilities.) There are going to be a lot of rotating doctors, and we do not want to deal with their other patients outside the nursing homes. (Mr. Atlas: How about attribution to the long-term care provider? We will consider it.) They were turned down on number of patients, not the facility. (Mr. Atlas: We need to look into the minimum number. We also do not want a great number of ACOs. We're hoping for maybe in the 10 range—not 100, not 50. Please send us comments. We only have two more meetings and a deadline from CMMI.)
- Dr. Herrera-Scott: Could the timeline be shared at the next meeting? (Mr. Atlas: We shared it first meeting. (Ms. Roddy: We are a little delayed in terms of what we laid out. And we are talking to CMMI about what is reasonable to accomplish by August. DHMH and HSCRC submitting together at the end of the year, and we need to think through that as well.)
- Mr. Altas unofficially proposed a path forward: MFFS and ACO as a sequence of events. (MFFS 1/18; ACOs 1/20, upside-only for first year; MFFS continues in white-space geographic areas; ACOs dominant model in 2021.)
    - Dr. Rifkin: What laid out is reasonable. Could you put it in writing before next meeting?
    - Ms. Kuchka-Craig: I am struggling with the fact that we have not had data. It is backwards to focus on models. We might learn in MFFS that we do not even want to go to an ACO approach. (Mr. Atlas: We did put out data—albeit old—but the makeup of duals population has not changed too much.) Why not some targeted interventions for those three distinct needs? (Ms. Roddy: Medstar decided on ACO as structure; within that there are targeted interventions. That is what we're talking about here. We determine the infrastructure first, through which we target interventions. During MMAC, Hilltop presented on InterRAI. They showed some really compelling data about the overuse of medications. What do you do with that information? How do you improve quality in the system? Right now we do not have a structure to do that. This

laid the case of what is not in place today, and why we need something for the duals. We get that there needs to be targeted interventions, but we need a structure—sending data back, managing LTSS, the acute care side. Hopkins has a number of programs.)

- Ms. Raswant: What we have seen in other states is structure and population of focus. One state is doing statewide MFFS, then Washington focused on high-risk, high-cost. This is not a homogenous population. (Ms. Roddy: There are Medicare ACOs—are you subdividing populations within those ACOs? We're only talking about 70,000 people statewide; we cannot start subdividing. Which would you focus on? From the State's perspective, we want something that will meet all needs. I do not know why you would only focus on one subset.)
- Mr. Atlas: The model could focus on all duals but make sure the care coordination is able to address the different needs of all duals.

Public Comments

- Michael Bullis (Executive Director, IMAGE Center for People with Disabilities): We see a lot of folks with LTSS needs, lots of duals. We hope programs like CAPABLE would be expanded and further tested. We primarily see care, not assessment. Nurses are looking for care-based solutions, not independence—support models that promote the long-term, bend the cost curve. We should look at this more before creating a system that does not focus much on people after they leave the hospital and go home. We are strong supporters of person-centeredness; asking a person with a significant disability what they want is difficult (especially the newly-disabled, as we might not know there is anything out there for them). We have to give people a certain level of knowledge to help them make decisions. (Mr. Atlas: We think the needs assessment would be honest and objective. If a person does not need health interventions but supports for their daily living, we cannot argue with that.)
- Ms. Eastman: In looking at the timeline, I understand need for exclusion the I/DD population; however, they experience poor health outcomes. Are they identified at all in your timeline/is there likelihood to integrate them later or modifications to the model to incorporate them later? (Ms. Roddy: That is our idea as well, that they will be integrated. We would love your input.) Will the model include preventive care in addition to acute, behavioral and LTSS? (Bob: Duly-noted.)
- Mr. DeMattos: We want to thank you and the team for working on this and to everyone for their contributions. I want to reiterate what Dr. Rifkin said—there is a lot of meat here, we need to take time to digest and come back to keep discussing.